Statement of

Andrew M. Wiesenthal, MD, SM

Associate Executive Director

The Permanente Federation

on behalf of the

Kaiser Permanente Medical Care Program

at the request of

Charles Kennedy, MD

Member, HIT Policy Committee

Office of the National Coordinator, Health Information Technology

December 15, 2009

Dr. Kennedy, members of the Committee, thank you for the invitation to be here today. I am Dr. Andy Wiesenthal, Associate Executive Director of the Permanente Federation.

I appear today on behalf of the national Kaiser Permanente Medical Care Program, the largest private integrated healthcare delivery system in the United States. In addition to the Permanente Medical Groups, it includes the Kaiser Foundation Health Plan, Inc. and the Kaiser Foundation Hospitals and their subsidiaries.

Kaiser Permanente is somewhat different from other payers represented here today. We are really an integrated health care delivery system that performs insurance functions for its members. Given that, it was natural for us to want to implement health information technology. Our intent in so doing was to promote the transformation of health care from our members' perspectives—improving their health outcomes, improving their experience of care, and improving the efficiency and effectiveness with which their premium dollars are spent on their care. Building on decades of experience, in 2003 we began the deployment of Kaiser Permanente HealthConnect®, our integrated electronic health record and health information system.

That deployment is largely complete— our 432 medical offices were integrated by April 2008, and only small pieces remain for 3 of our more than 30 owned and operated hospitals. We have trained more than 14,000 physicians and 150,000 other staff, all of whom use the system all of the time for their work. HealthConnect represents the sole medical record for all of our 8.6 million members, more than 3.2 million of whom are

active users of our patient portal/PHR. They regularly exchange more than 750,000 secure messages with their physicians per month, they have reviewed tens of millions of their lab results, refilled millions of prescriptions, made millions of appointments, and reviewed post-encounter advice and instructions from their clinicians. We are putting information and transactions formerly reserved for health care workers into the hands of our members. They are better at it than the health care workers ever were, and they prefer being the locus of control for their own health care as it relates to these functions.

Beyond that, we are using the data we collect and aggregate to promote standardization around best evidence and more coordinated care of members with chronic diseases. There are many examples of success. Combining KP HealthConnect, registry tools, and a follow-up team comprising pharmacists and nurses, we have reduced post-AMI all cause ten-year mortality by more than 70%. Nothing fancy, just identifying the at-risk members and aggressively supporting them as they attempt to reduce their lipids, lower their blood pressure, get more exercise, and lose weight. Using similar techniques, we have also shown that we can slow the progression and even prevent the progression of insulin-dependent diabetics to end-stage renal disease requiring dialysis.

Our oncologists, oncology nurses, and clinical oncology pharmacists have designed evidence-based treatment plans for more than 400 of the common adult malignancies. These, along with the already standardized pediatric treatment plans, are instantiated into KP HealthConnect and are being used for all members with cancer. We expect to dramatically increase the safety of care as well as the efficacy of care for these members.

All members may take an on-line health risk assessment (HRA) using a standard tool. The results are incorporated into their medical record after being brought to the attention

of their primary care physician. The member may then, on the basis of the results, be assisted in taking advantage of on-line self-management tools for a range of issues identified by the HRA. These tools are available to all members, whether they take the HRA or not. They receive periodic on-line reminders about their self-developed plan, and they are offered opportunities to retake the HRA to gauge their progress against goals.

Beyond having access to all medical records from wherever they are, physicians have on-the-desktop, real-time access to data about their member panels, including both summary data and data identifying primary preventive care gaps for every member, and they are shown secondary preventive and treatment care gaps for members with an array of chronic medical problems. Virtually everyone else in the organization also has role-based access to KP HealthConnect. Whenever they encounter a member, be it in person, on the phone, or on the web, they are presented with alerts related to preventive health and chronic disease management for that particular member. They have the authority to urge the member to have recommended tests and interventions, which are ordered under protocol from the member's physician. Thus receptionists, pharmacists, call center nurses, and specialty physicians are all part of an expanded primary care team taking accountability for assisting members in adhering to recommended treatment and prevention plans. As a result, our rates of a number of primary and secondary prevention interventions are consistently now among the best in the nation. One need look no further than our HEDIS measures in mammography and Chlamydia screening for proof of that assertion.

None of this was necessarily easy. We have learned as much about what not to do in deploying health information technology to end-users as we have learned about best deployment practices. Stated in a positive sense, budgets need to be protected over several years; projects must be managed by clinicians, not by information technology professionals; care transformation goals must be identified and targeted from the outset; customize commercial software at your peril; and automation exacerbates the problems associated with workflows that are already cumbersome.

As we design our successful interventions, members are at the center of our thinking and are often part of the design process itself. It is critical to understand how they want to view and use data and clinical advice. The platform we have built in KP HealthConnect was configured and deployed with those ends in mind, and our early results are more than encouraging. I am grateful for this opportunity to share some of our successes, and to describe the lessons learned from our experiences. Thank you for the chance to be here today.